Corporate Profit or Public Good?

BEVERLEE A. MYERS, MPH, *Los Angeles*
Professor and Head, Division of Health Services, University of California, Los Angeles, School of Public Health, and former Director, California Department of Health Services, Sacramento

THE ULTIMATE AIM of American medicine is to serve the health and medical needs of all people. Individual practitioners will continue to practice medicine on behalf of themselves, their patients and society, with the frequently conflicting objectives that those constituencies demand.[1] The difficult issue in the next decade is less the goals of American medicine and more the means through which those goals are to be accomplished: under what circumstances and under whose control will the health and medical needs of people be met?

In the 1960s there appeared to be a political consensus that access to health care was a right and choices were made to implement that right. The choice was not a single national health program but a series of programs aimed at priority targets—Medicare for the elderly, Medicaid for some of the poor, community health centers, National Health Service Corps in underserved areas—and to provide the personnel and knowledge necessary—federal support for health professions education, increased support of biomedical research, Regional Medical Programs, Area Health Education Centers.

These programs, together with private sector initiatives, improved equity of access: the poor and the elderly increased their physician visits; infant mortality rates declined dramatically; age-specific mortality rates at all ages declined. But there were also problems: most of the poor were not reached by Medicaid; the programs were more costly than expected, and waste, fraud and abuse by government, providers and beneficiaries seemed rampant. Government was judged to be an inefficient manager of its 40% share of national health expenditures.

The climate and the ideology began to change in the late 1970s—the right to health care was no longer axiomatic, it would have to be justified, measured, limited. Health care was no longer a public good to be made available without constraints. Health care like other goods and services would have to be rationed; choices must consider cost-effectiveness.

In 1985 a prominent Wall Street firm issued a research report modestly entitled "The Future of Health Care Delivery in America." Its major conclusions were

> The U.S. health care system is about to undergo a radical transformation. Reorganization will take the form of a wide array of economically based delivery systems that will be truly competitive and completely deregulated. As health maintenance organizations and preferred provider organizations proliferate, the current anarchic and uncontrolled fee-for-service system will be displaced by what could be called 'competitive socialized medicine,' which will control utilization, insure quality, and restrain pricing. In all this the true winner will be society, not the health industry.[2(p11)]

The societal winner in this scenario appears to be the business community. One sentence buried in the report refers to the losers: "In this system, independent and charity patients will be able to obtain care only in state, city, or county-supported hospitals."[2(p55)]

The market, and its competitive forces, is inherently inequitable and cannot be held accountable. When reliance is placed primarily on the market, and when at the same time government regulation and support is reduced, the consequences can be severe for the losers. We know that hospitals are now making record profits but are increasingly turning away the uninsured.[3] We also know that when poor people have recourse only to overcrowded and underfunded public hospitals, many have difficulty getting needed care and their health status deteriorates.[4]

In these last two decades the profession has tended to concentrate on issues of quality of care and improved technology, leaving to government and the market the assurance that standards of equity and efficiency are met. But, whether they are subject to government's inefficiencies or the inequities of a new "competitive socialized medicine," it will still be physicians who ultimately determine how this nation spends 10% of its gross national product. But if the Wall Street prognosticators are accurate, the health care market is seriously overbalancing in the direction of efficiency and cost containment at the expense of quality and access.

(Myers BA: Corporate profit or public good?—*In* The aim of American medicine within the constraints of today's society—A forum. West J Med 1986 Aug; 145:189-190)

Reprint requests to Beverlee A. Myers, MPH, Professor and Head, Division of Health Services, UCLA School of Public Health, Los Angeles, CA 90024.

The Aim of American Medicine

The question for American medicine is with whom is it most willing to collaborate: an admittedly inefficient government or an inherently inequitable market? Under whose controls will it best be able to pursue quality and service: government socialized medicine or competitive socialized medicine?

If we continue as Wall Street predicts, the problems of the poor, of the uninsured and underserved, of a two-class health system, will become more and more apparent—even to the point of a reversal of recent positive health status trends. This will stimulate renewed discussion, by the professions and by consumers, of a national health program. Enactment of such a program that melds the capabilities and interests of the profession for quality, of the market for efficiency and of the government for equity is, it seems to me, inevitable before the end of the century. Given the experience in most other industrialized countries, it is also a desirable direction.

REFERENCES

1. Eisenberg J: Physician utilization: The state of research about physicians' practice patterns. Med Care 1985; 23:461-483
2. Abramowitz KS: The Future of Health Care Delivery in America. Bernstein Research. New York, Sanford C. Bernstein & Co, Inc, 1985
3. Hospitals score record profits under DRGs. Am Med Assoc News, Aug 9, 1985, pp 1, 18
4. Lurie N, Ward NB, Shapiro MF, et al: Special report: Termination from Medi-Cal—Does it affect health? N Engl J Med 1984, 311:480-484

The Credo of an Honored Profession

LONNIE R. BRISTOW, MD, *San Pablo, California*

Trustee, American Medical Association, and Past President, American Society of Internal Medicine

TO DEFINE THE AIM of American medicine in today's environment, we must first know what is unique about American medicine.

When I am asked that question, it always reminds me of a story told about Benjamin Franklin. It is said that, as he left the meeting concluding the constitutional convention in 1787, a member of the waiting crowd asked him, "Mr Franklin, what kind of government have you given us—a monarchy or a federation?" He replied, "A federation, my boy, *if* you can keep it." If one were to instead ask, "What singular quality makes American medicine unique?", the paraphrased answer would be: "It is an honored profession, my boy, *if* you can keep it."

What is a profession? Traditionally, it is a field of endeavor requiring specialized knowledge obtained by prolonged and concentrated study—knowledge much beyond what the average person can be expected to obtain. Because of their acknowledged value to society, professionals are accorded certain privileges and honors, such as the privilege of self-discipline. In return, they are expected to apply this knowledge for the betterment of the greater society. In the field of medicine that professional credo can be summed up quite simply. It is "healing first and dollars second."

American medicine is currently locked in a struggle, seeking to preserve and pass on its heritage to the next generation. For the last ten years, our profession has experienced a series of hammering attacks from the "four horsemen of commercialism." They are big government, big business, the insurance complex and the hospital industry. If they had their way, the four horsemen of commercialism would change the credo of medicine from "healing first and dollars second" to "profits first and healing second."

Recently we have seen the corporate acquisition of medical schools, and a health maintenance organization in southern California advertising that its hospital will kick back a portion of profits to those doctors admitting patients with medical diagnoses that result in big profits to the hospital under the new Medicare system. I submit that professionalism itself is in an undeclared war, attacked by those committed to "bottom line" thinking.

Let me illustrate with a chilling anecdote. I recently appeared as a witness before the Prospective Payment Assessment Commission (PROPAC) in Washington, DC, along

(Bristow LR: The credo of an honored profession—*In* The aim of American medicine within the constraints of today's society—A forum. West J Med 1986 Aug; 145:190-191)

Reprint requests to Lonnie R. Bristow, MD, 2023 Vale Road, San Pablo, CA 94806.